STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155702	A. BUILDING 00 B. WING	04/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARING HANDS HEALTH CARE CENTER	1850 MATADOR ST PERU, IN46970

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F0000	This visit was for the Investigation of Complaint #IN00087748. Complaint #IN00087748- Substantiated, Federal/State deficiencies related to the allegations are cited at F152 and F250. Unrelated deficiencies cited. Survey dates: April 6 & 7, 2011 Facility number: 003130 Provider number: 155702 AIM number: 200386750 Survey team: Honey Kuhn, RN, TC Census bed type: SNF: 3 SNF/NF: 79 Total: 82 Census payor type: Medicare: 14 Medicaid: 49 Other: 19 Total: 82 Sample: 3 These deficiencies also reflect State	F0000	The following plan of correction or any corrective action set forth herein does not constitute an admission or agreement by Caring Hands Health Care Center of the facts alleged or the conclusions set forth in the statement of deficiencies. The Plan of Correction and corrective action are prepared and executed solely as provisions of Federal and State law. Caring Hands Health Care Center requests that this plan of correction be considered the facilities credible allegation of compliance. Completion Date: 05/07/2011	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	findings cited in accordance with 410 IAC 16.2. Quality review completed on April 11, 2011 by Bev Faulkner, RN			
F0152	In the case of a resident adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under State law to act on the resident's behalf. In the case of a resident who has not been judged incompetent by the State court, any legal surrogate designated in accordance with State law may exercise the resident's rights to the extent provided by State law.			
SS=D	Based on record review and interviews, the facility failed to address issues of current and future medical care for blood transfusions was thoroughly addressed following the refusal of a physician's order by the resident's POA (Power of Attorney) on the religious convictions of the POA. This deficiency effected 1 of 3 residents reviewed in a sample of 3 residents requiring blood	F0152	I. Corrective Actions taken for those residents affected by the alleged deficient practice: Resident E: The facility administrative staff conducted a phone conference with legal counsel on April 12, 2011 for guidance on this issue. Upon review of all prior POA/Guardianship paperwork, it was determined that none were currently in effect. Thus, Caring Hands must follow Indiana law to define those individuals who are authorized to consent to health care for Resident E. A letter was formulated and mailed to both daughters involved. A phone message was left with both, appraising them of the imminent arrival of this communication. The individual who is named in	05/07/2011

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	transfusions. (Resident "E") Finding includes: The records of Resident "E" were reviewed on 04/07/11 at 8:45 a.m. Resident "E" was admitted to the facility on 08/01/06 with diagnoses including, but not limited to, seizures, hydrocephalus, dysphasia (difficulty swallowing), head injury, and hypertension. Review of labs indicated Resident "E" had been monitored frequently for low hemoglobin (the iron containing pigment of the red blood cells that carries oxygen from the lungs to body tissues.) A CBC (Complete Blood Count) done on 02/23/11, indicated a Hgb (Hemoglobin)		the power-of-attorney and health care representative appointment is qualified under Indiana law to consent to or withhold consent to health care for this resident. The facility could not take a position in opposition to the health care representative, regardless of whether the facility agreed with that decision. II. Identification of and corrective actions taken for other residents having the potential to be affected by the alleged deficient practice: a) All resident records will be audited for any obvious conflict in determination of who will be the consenting party for health care decisions. III. Measures taken and systemic changes made to ensure the alleged deficient practice does not recur: a) Upon admission all residents guardianship / POA status will be determined and paperwork reviewed by Social Service. If obvious discrepancies exist, a meeting will be held with family and resident, and/or legal counsel to determine proper guidance. the facility will require residents and families to appoint a surrogate to make health care determinations. b) Upon known changes in guardianship / POA status, meetings will be called with resident and family; and/or legal counsel to determine who may give consent when residents are unable to do so. And, a surrogate decision-maker will be identified. IV. How the corrective	

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	of 7.5 with a reference range (normal range) of 14.0-18.0. A physician's order, dated 02/23/11, indicated, "Transfuse 2 units PRBCs (Packed Red Blood Cells); may do in a.m...." Review of Nurse's Notes indicated: "02/23/11 1125 (11:25 a.m.) Res (POA #1 name) called & she gave permission for res (resident) to have consult c (with) a surgeon... 02/23/11 1130 (11:30 a.m.) Also res (POA #1) stated if res needed surgery he could not have a blood transfusion. States it's against her (POA # 1) religion...." 02/23/11 6:45 p.m., ...(.POA #2 name) notified-she stated OK.		actions will be monitored and the QA system implemented to ensure the alleged deficient practice does not recur: a) Social Service will audit resident guardianship/POA documents on a quarterly basis (in coordination with Care Plan meetings) to discover any obvious changes in status and to address timely with families and/or other agencies. b) Social Service will report monthly to the QA committee the results of this audit for further action by administration and/or legal counsel as necessary.	

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	02/24/11 1230 (12:30 p.m.) Resident sent to (ACF: Acute Care Facility: hospital) r/t (related to) low Hgb of 7.5. Res is to receive 2 units PRBC. (POA #2 name) notified. She stated "OK & thank you" & to please notify here (sic) when res returns to facility... 02/24/11 1520 (3:20 p.m.) Received NO (New Order) to D/C (discontinue) transfusion @ (at) this x (time) per (POA #1) request. DON (Director of Nursing) notified. 02/24/11 1600 (4:00 p.m.) Spoke c resident's POA (name #1) r/t her decision to stop blood transfusion @ this time. (POA #1 name) states that she (POA #1) is a Jehovah Witness & God would not want her brother to get a transfusion.			

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	(POA #1) states that she is the only person to make decisions for resident & she does not want (POA #2) influencing any decisions.... 02/25/11 10:30 a.m. Contacted (POA #1). ...have been told by mother (name) & (POA #2) that resident had always been Baptist....(POA #1) stated she is the Jehovah Witness, did not deny or confirm that resident is Baptist just stated he had been to "meetings" before....Discussed with (POA #1) that decisions for resident should act in his best interest & based on his belief system..." A CBC done on 03/10/11, indicated a Hgb of 7.0. A physician's order, dated 03/10/11, indicated, "Transfuse 2 units PRBC's (Packed Red			

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	Blood Cells)..." Review of Nurses Notes indicated: "03/11/11 1930 (7:30 p.m.) Late entry for 03/11/11 @ 1645 (4:45 p.m.). ...Blood transfusion ordered if POA agrees & will consent for procedure. POA contacted by this writer and Social Services Director. (POA #1 name) informed of the lab value & updated on resident's status. POA was informed that resident has demonstrated declines in condition. Resident is noted to have pale skin color/nailbeds, increase fatigue, often reuses to get OOB (out of bed) & refuses meals...POA verbalizes understanding of the Hgb as well as the decline in condition. POA continues to			

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	refuse the blood transfusion r/t religious beliefs. POA did agree to come in to facility this week to assess resident & talk c administrative staff..." Review of Social Service notes indicated an entry on 01/27/11. The next entry indicated: "03/09/11 IDT (Interdisciplinary Team: a team composed of staff from various departments to address resident needs) care plan meeting held. Resident and family invited but not in attendance. He continues DNR (Do Not Resuscitate: no life saving measures in event of heart or breathing stoppage) code status c Advance Directives in place in chart. His POA is his sister (name of POA #1). Care plans, no changes made @ this time."			

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	"03/22/11 Behavior report received on 03/22/11, dated 03/21/11 @ resident feeling down, depressed & hopeless. When getting ready for bed, resident kept asking staff to kill him. Staff talked to resident and behavior stopped." "03/23/11 SSD (Social Service Designee) looking in overflow finding documents giving POA (HCP) (Health Care Power of Attorney) to (POA #1 name) and (POA #2 name) secondary from residents mother (name). Both (POA #1) and (POA #2) notified any (sic) in agreeance (sic) c forms....no further concerns." Review of documentation provided by the facility for Resident "E" indicated			

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	"Durable Health Care Power of Attorney" forms signed on 05/05/06, prior to the admission of Resident "E" to the facility. The document indicated, "...It is my desire to receive appropriate medical treatment so long as there is a reasonable hope of recovery,..." The forms were signed by POA #1 as primary and POA #2 as secondary Health Care Agents. Interview with the Corporate RN, on 04/07/11 at 11:30 a.m., indicated Resident "E" had a Hgb of 7.6 on 04/07/11 and an order for transfusion if Hgb dropped to 7.5 or lower. The Corporate RN indicated there was no resolution in regards to the issue of POA #1's religious beliefs and the issue would again need to be addressed.			

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	Interview with the Administrator, on 04/07/11, at 11:00 a.m., indicated he was involved with the issues and the facility had met with POA #1 but had not documented the meeting. The Administrator indicated the mother of Resident "E" is the guardian of the resident. The mother of Resident "E" has since declined and is now herself a resident in the facility and not interviewable. The Administrator further indicated there was disagreement between POA #1 and POA #2 in regards to blood administration for Resident "E". The Administrator indicated POA #2 wanted Resident "E" to receive the blood transfusion as it was not against the religious beliefs the resident was raised with. The			

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	Administrator indicated during discussion of family issues with POA #2 he "cannot use my nurses station as a battleground." The Administrator indicated there was no documentation in regard to the facility addressing the medical issues and the facility was abiding by the wishes of POA #1. This Federal Tag relates to Complaint #IN00087748. 3.1-3(c)			
F0250 SS=D	The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on record review and interviews, the facility failed to ensure a resident's need for a	F0250	I. Corrective actions taken for those residents affected by the alleged deficient practice: Resident E: The facility administrative staff conducted a	05/07/2011

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	blood transfusion was thoroughly addressed following the refusal of a physician's order by the resident's POA (Power of Attorney) on the religious convictions of the POA. This deficiency effected 1 of 3 residents reviewed in a sample of 3 residents requiring blood transfusions. (Resident "E") Finding includes: The records of Resident "E" were reviewed on 04/07/11 at 8:45 a.m. Resident "E" was admitted to the facility on 08/01/06 with diagnoses including, but not limited to, seizures, hydrocephalus, dysphasia (difficulty swallowing), head injury, and hypertension.		phone conference with legal counsel on April 12, 2011 for guidance on this issue. Upon review of all prior guardianship/POA paperwork, it was determined that none were currently in effect. Thus, Caring Hands must follow Indiana law to define those individuals who are authorized to consent to health care for Resident E. A letter was formulated and mailed to both daughters involved. A phone message was left with both appraising them of the imminent arrival of this communication. Regardless, the survey allegations on their face do not demonstrate that Caring Hands did not provide necessary and appropriate Social Services to this resident especially in light of the fact that the facility followed the decision of the appointed health care representative. Also, the facility's legal counsel contacted the health care representative and advised her to discuss her objections to the physician-ordered health care with the physician himself. The facility could not take a position in opposition to that of the health care representative regardless of whether the facility agreed with that decision -- thus, this is not a failure to provide social services. II. Identification of and corrective actions taken for other residents having the potential to be affected by the alleged deficient practice: a) All resident records will be	

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	Review of labs indicated Resident "E" had been monitored frequently for low hemoglobin (the iron containing pigment of the red blood cells that carries oxygen from the lungs to body tissues.) A CBC (Complete Blood Count) done on 02/23/11, indicated a Hgb (Hemoglobin) of 7.5 with a reference range (normal range) of 14.0-18.0. A physician's order, dated 02/23/11, indicated, "Transfuse 2 units PRBCs (Packed Red Blood Cells); may do in a.m...." Review of Nurse's Notes indicated: "02/23/11 1125 (11:25 a.m.) Res (POA #1 name) called & she gave permission for res (resident) to have consult c (with) a surgeon...		audited for any obvious conflict in determination of who will be the consenting party for health care decisions. III. Measures taken and systemic changes made to ensure the alleged deficient practice does not recur: a) Upon admission all residents guardianship / POA status will be determined and paperwork reviewed by Social Service. If obvious discrepancies exist, a meeting will be held with family and resident, and/or legal counsel to determine proper guidance. The facility will require residents and families to appoint a surrogate to make health care determinations. b) Upon known changes in guardianship / POA status, meetings will be called with resident and family; and/or legal counsel to determine who may give consent when residents are unable to do so. A surrogate decision-maker will be identified. IV. How the corrective actions will be monitored and the QA system implemented to ensure the alleged deficient practice does not recur: a) Social Service will audit resident guardianship/POA documents on a quarterly basis (in coordination with Care Plan meetings) to discover any obvious changes on status and to address timely with families and/or other agencies. b) Social Services will report monthly to the QA committee the results of this audit for further action by administration and/or	

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	Nursing) notified. 02/24/11 1600 (4:00 p.m.) Spoke c resident's POA (name #1) r/t her decision to stop blood transfusion @ this time. (POA #1 name) states that she is a Jehovah Witness & God would not want her brother to get a transfusion. (POA #1) states that she (POA #1) is the only person to make decisions for resident & she does not want (POA #2) influencing any decisions.... 02/25/11 10:30 a.m. Contacted (POA #1). ...have been told by mother (name) & (POA #2) that resident had always been Baptist....(POA #1) stated she is the Jehovah Witness, did not deny or confirm that resident is Baptist just stated he had been to "meetings"			

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	before....Discussed with (POA #1) that decisions for resident should act in his best interest & based on his belief system..." A CBC done on 03/10/11, indicated a Hgb of 7.0. A physician's order, dated 03/10/11, indicated, "Transfuse 2 units PRBC's (Packed Red Blood Cells)..." Review of Nurses Notes indicated: "03/11/11 1930 (7:30 p.m.) Late entry for 03/11/11 @ 1645 (4:45 p.m.). ...Blood transfusion ordered if POA agrees & will consent for procedure. POA contacted by this writer and Social Services Director. (POA #1 name) informed of the lab value & updated on resident's status.			

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	155702	A. BUILDING 00 B. WING	04/07/2011

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	POA was informed that resident has demonstrated declines in condition. Resident is noted to have pale skin color/nailbeds, increase fatigue, often reuses to get OOB (out of bed) & refuses meals...POA verbalizes understanding of the Hgb as well as the decline in condition. POA continues to refuse the blood transfusion r/t religious beliefs. POA did agree to come in to facility this week to assess resident & talk c administrative staff..." Review of Social Service notes indicated an entry on 01/27/11. The next entry indicated: "03/09/11 IDT (Interdisciplinary Team: a team composed of staff from various departments to address resident needs) care plan meeting held.			

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	Resident and family invited but not in attendance. He continues DNR (Do Not Resuscitate: no life saving measures in event of heart or breathing stoppage) code status c Advance Directives in place in chart. His POA is his sister (name of POA #1). Care plans, no changes made @ this time." "03/22/11 Behavior report received on 03/22/11, dated 03/21/11, @ resident feeling down, depressed & hopeless. When getting ready for bed, resident kept asking staff to kill him. Staff talked to resident and behavior stopped." "03/23/11 SSD (Social Service Designee) looking in overflow finding documents giving POA (HCP) (Health Care Power of Attorney) to (POA #1 name)			

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	and (POA #2 name) secondary from residents mother (name). Both (POA #1) and (POA #2) notified any (sic) in agreeance (sic) c forms....no further concerns." The SSD was unavailable for interview. Interview with the Administrator, on 04/07/11, at 11:00 a.m., indicated he was involved with the issues and the facility had met with POA #1 but had not documented the meeting. Interview with the Corporate RN, on 04/07/11 at 11:30 a.m., indicated Resident "E" had a Hgb of 7.6 on 04/07/11 and an order for transfusion if Hgb dropped to 7.5 or lower. The Corporate RN indicated there was no resolution in regards to the issue of POA #1's religious			

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	beliefs would again need to be addressed. This Federal Tag relates to Complaint #IN00087748. 3.1-34(a)			
F0272	The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information			

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	regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment.			
SS=D	Based on record review and interviews, the facility failed to ensure physician's orders were followed and a resident assessed after the administration of blood. This deficiency affected 1 of 3 residents in a sample of 3 who had orders for blood transfusions. (Resident "C") Finding includes: The record of Resident "C" was reviewed on 04/06/11 at 10:05 a.m. Resident "C" was admitted to the facility on 01/20/11 with diagnoses including, but not limited	F0272	I. Corrective actions taken for those residents affected by the alleged deficient practice: Resident C has documentation from the hospital that includes assessment pre-transfusion, during transfusion, and post-transfusion. The hospital documentation also includes medications administered per MD order during the transfusion. The nurse @ LTC included a follow-up entry in the chart whtat resident C had returned from the hospital and no adverse reactions were noted. The nurse also completed a daily skilled note with Vital Signs when resident returned from the hospital. Thus, contrary to the survey allegations, thre was a post-transfusion nursing assessment. II. Identification of and corrective actions taken for other residents having the potential to be affected by the alleged deficient practice: a) All residents scheduled for outpatient procedures have the potential to be affected by the alleged deficient practice. III. Measure taken and systemic changes made to ensure the alleged deficient practice does not recur: a) All nursing staff will be re-inserviced on the policy to follow for post out-patient procedures. Additionally, a new	05/07/2011

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	to, COPD (Chronic Obstructive Pulmonary Disease), CHF (Congestive Heart Failure), pacemaker, CRI (Chronic Renal Insufficiency), diabetes, hyperkalemia (high Potassium levels), and hypertension. Review of laboratory tests since admission indicated on 03/20/11, the resident had a Hgb (Hemoglobin: the iron containing pigment of the red blood cells that carries oxygen from the lungs to body tissues.) of 7.9 with a reference range (normal range) of 12.0-15.0). Review of physician's orders indicated:		computerized documentation system (electronic health record) has been implemented. Nursing staff will be re-inserviced by April 25, 2011. The facility will maintain documentation from the outpatient center in the overflow resident records and will be available upon request. IV. How the corrective actions will be monitored and the QA system implemented to ensure the alleged deficient practice does not recur: a) The DON or designee will monitor all resident charts that have outpatient procedures for accuracy weekly X 4 weeks; then monthly X 6 months. The results will be reviewed in monthly QA committee meetings.	

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	"03/29/11 1430 (2:30 p.m.) Type et (and) Crossmatch two units packed red blood cells. Transfuse two units when available." "03/30/11 Lasix 20 mg IV p (after) ea (each) unit of blood. Indication: CHF." Review of Nurses Notes indicated: "03/30/11 0130 (1:30 a.m.) Scheduled for blood transfusion 0800 (8:00 a.m.) "0/330/11 1845 6:45 p.m.) Res (resident) returned from hospital from blood transfusion. 0 (no) adverse reactions noted." The Corporate RN was			

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	interviewed on 04/06/11 at 11:00 a.m., in the absence of the DNS (Director Nursing Services), in regards to post transfusion assessments and the administration of the Lasix. The Corporate RN indicated the facility did not have a specific policy in regards to post transfusions but the resident should have been assessed upon return to the facility. The Corporate RN indicated the facility sends the physician's orders for transfusions as well as associated orders, including medications, with the residents when the resident			

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	leaves the facility for the ACF (Acute Care Facility: hospital). The Corporate RN indicated the 2 Lasix doses would have been administered at the ACF and the ACF sends documentation to indicate it was given when the resident returns to the facility. The record did not contain any information the resident received the ordered doses of Lasix. Review of the "SKILLED DAILY NURSES NOTE", a focused charting tool for resident's receiving skilled care, indicated the resident's V/S's (Vital Signs: blood pressure, temperature, pulse and			

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	respirations) were checked prior to leaving for blood transfusions and again on the night shift. There was no indication the resident was assessed upon return to the facility on the evening shift. 3.1-31(c)(6)			
F0333 SS=D	The facility must ensure that residents are free of any significant medication errors. Based on record review and interviews, the facility failed to ensure 1 of 2 residents in a sample of 3 had received the correct dosage of Levothyroxine(a medication to treat thyroid) since admission on	F0333	I. Corrective actions taken for those residents affected by the alleged deficient practice: Resident C: All physician orders have been reviewed and clarified with the attending physician. II. Identification of and corrective actions taken for other residents having the potential to be affected by the alleged deficient practice: a) All residents have the potential to be affected by the alleged deficient practice. III. Measures taken and systemic changes made to ensure the alleged	05/07/2011

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	01/10/11. (Resident "C") Finding includes: The record of Resident "C" was reviewed on 04/06/11 at 10:05 a.m. Resident "C" was admitted to the facility on 01/10/11 with diagnoses including, but not limited to, hypothyroidism (low thyroid levels), COPD (Chronic Obstructive Pulmonary Disease), CHF (Congestive Heart Failure), pacemaker, CRI (Chronic Renal Insufficiency), diabetes, hyperkalemia (high Potassium levels), and hypertension. The record indicated a		deficient practice does not recur: a) Nursing staff will be re-inserviced on the following policy and procedures: Physician orders; Transcription of physician orders; Monthly re-cap of physician orders; and Medication errors. All inservicing will be completed by April 25,2011. b) Unit managers or designee will review all physician orders 5 days per week for accuracy. c) Medication administration audits will be conducted by the DON or designee to ensure accuracy and completion. IV. How the corrective actions will be monitored and the QA system implemented to ensure the alleged deficient practice does not recur: a) DON or designee will review the medication administration audits weekly x 4 weeks; then monthly x 6 months; then quarterly thereafter. Results will be reviewed in monthly QA committee meetings on-going.	

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	discrepancy in regards to Resident "C" receiving Levothyroxine and indicated: A physician's order "01/10/11 Synthroid (a brand name for Levothyroxine) 125 mcg tablet. 1 PO (Per os: by mouth) dly (daily)". A MARs: dated "01/10/11" indicated: "Synthroid 137 mcg dly (daily)" and doses administered: 01/12/11 01/13/11 01/14/11 01/15/11 A physician's order: "01/20/11 Levothyroxine			

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	0.125 mcg (micrograms) oral daily." "01/20/11" MARs (Medication Administration Record): "Levothyroxine 137 mcg PO (Per os: by mouth) daily" and doses documented as given on: 01/22/11 01/23/11 01/24/11 01/25/11 On 01/26/11 the MARs is noted "see N.O. (New Order)." Review of the physicians orders indicated: "01/25/11 Clarifications:...DC Levothyroxine 137 mcg. Levothyroxine 125 mcg."			

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	Review of the printed Physicians Orders for 02/2011 indicated: "01/10/11 Levothyroxine 125 mcg tablet. Give 1 tablet orally once a day." The printed order was noted to have a handwritten slash through the "125 mcg" and a handwritten "137" written above the printed 125 mcg. Review of the MARs for 02/2011 indicated Levothyroxine 125 mcg tablet. Give 1 table orally once a day." The documentation indicated the 125 mcg dose was given every day in 02/2011. Review of the printed			

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	Physicians Orders for 03/2011 indicated: "01/20/11 Levothyroxine 137 mcg tablet. Give 1 tablet orally once a day." Review of the MARs for 03/2011 indicated Resident "C" received 137 mcg every day in 03/2011, as ordered. Review of the printed Physician Orders for 04/2011 indicated: "02/24/11 Levothyroxine 125 mcg tablet. Give 1 tablet orally once a day." Review of the MARs for 04/2011 for 04/0/11 through 04/06/11 indicated Resident			

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	"C" had received the ordered dose of 125 mcg. The medication cart was checked and the correct dosage supply was observed for Resident "C". All Physicians Orders were signed as reviewed by 2 nurses and the physician. The Physicians Orders for 02/2011 were signed by the Consultant Pharmacist. All MARs reviewed were signed as reviewed by 2 nurses. The Corporate Nurse was interviewed, in the absence of the DNS (Director Nursing Services), on 04/06/11 at 11:00 a.m. The			

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	Corporate Nurse indicated being unaware of the discrepancies of Levothyroxine dosages since admission. The Corporate Nurse could not verify the medications were administered as ordered. LPN #2 was queried on 04/07/11 at 11:00 a.m., in regards to the Levothyroxine dosage. LPN #2 indicated the correct doses were always sent and administered. LPN #5 was queried on 04/07/11 at 11:05 a.m., in regards to the Levothyroxine dosage. LPN #5 indicated the			

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	pharmacy sent the correct dosage. When queried in regards to the discrepancy between the physician's ordered dosage and the MARs, both nurses were unaware of the discrepancy and could not verify the correct dosage was administered in January, February or March of 2011. The Corporate Nurse, on 04/07/11, indicated Resident "C" Levothyroxine dosage was to have been 125 mcg since admission. 3.1-25(b)(3)			

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F0514	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.			
SS=D	Based on record review and interviews, the facility failed to ensure accurate documentation in regards to 1 resident receiving ordered medications for 1 of 1 residents in a sample of 3. (Resident "C") Finding includes: The record of Resident "C" was reviewed on 04/06/11	F0514	I. Corrective actions taken for those residents affected by the alleged deficient practice: Resident C: All physician orders have been reviewed and clarified with the attending physician. II. Identification of and corrective actions taken for other residents having the potential to be affected by the alleged deficient practice: All residents have the potential to be affected by the alleged deficient practice. III. Measures taken and systematic changes made to ensure the alleged deficient practice does not recur: a) Nursing staff will be inserviced on the following policy and procedures: Physician orders; Transcription of physician orders; Monthly re-cap of Physician orders; and Medication errors. All inservicing will be completed by April 25,2011.b) Unit managers	05/07/2011

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	155702	A. BUILDING 00 B. WING	04/07/2011

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	at 10:05 a.m. Resident "C" was admitted to the facility on 01/10/11 with diagnoses including, but not limited to, hypothyroidism (low thyroid levels), COPD (Chronic Obstructive Pulmonary Disease), CHF (Congestive Heart Failure), pacemaker, CRI (Chronic Renal Insufficiency), diabetes, hyperkalemia (high Potassium levels), and hypertension. Review of the record for Resident "C" indicated a physician's order: "01/25/11....Kayexalate 30 mgl (milliliters) X 1..." "01/26/11 1. 30 g (grams) Kayexalate now....".		or designee will review all physician orders 5 days per week for accuracy. c) Medication administration audits will be conducted by the DON or designee to ensure accuracy and completion. IV. How the corrective action will be monitored and the QA system implemented to ensure the alleged deficient practice does not recur: DON or designee will review the medication administration audits weekly x 4 weeks; then monthly x 6 months; then quarterly thereafter. Results will be reviewed in monthly QA committee meetings - ongoing.	

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	Review of a MARs (Medication Administration Record) for 01/20/11 through 01/31/11, did not indicate the Kayexalate was given on 01/25/11 or 01/26/11. "03/15/11 1. Kayexalate 30 gm po X 1..." Review of the MARs for 03/2011 did not indicate the Kayexalate was given. The record indicated a discrepancy in regards to Resident "C" receiving Levothyroxine and indicated: A physician's order "01/10/11 Synthroid (a brand name for Levothyroxine) 125 mcg			

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	tablet. 1 PO (Per os: by mouth) dly (daily)". A MARs: dated "01/10/11" indicated: "Synthroid 137 mcg dly (daily)" and doses administered: 01/12/11 01/13/11 01/14/11 01/15/11 A physician's order: "01/20/11 Levothyroxine 0.125 mcg (micrograms) oral daily." "01/20/11" MARs (Medication Administration Record): "Levothyroxine 137 mcg PO (Per os: by mouth) daily" and doses			

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	documented as given on: 01/22/11 01/23/11 01/24/11 01/25/11 On 01/26/11 the MARs is noted "see N.O. (New Order)." Review of the physicians orders indicated: "01/25/11 Clarifications:...DC Levothyroxine 137 mcg. Levothyroxine 125 mcg." Review of the printed Physicians Orders for 02/2011 indicated: "01/10/11 Levothyroxine 125 mcg tablet. Give 1 tablet orally once a day." The printed order was noted to have a handwritten slash			

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	through the "125 mcg" and a handwritten "137" written above the printed 125 mcg. Review of the MARs for 02/2011 indicated Levothyroxine 125 mcg tablet. Give 1 table orally once a day." The documentation indicated the 125 mcg dose was given every day in 02/2011. Review of the printed Physicians Orders for 03/2011 indicated: "01/20/11 Levothyroxine 137 mcg tablet. Give 1 tablet orally once a day." Review of the MARs for 03/2011 indicated Resident			

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	"C" received 137 mcg every day in 03/2011, as ordered. Review of the printed Physician Orders for 04/2011 indicated: "02/24/11 Levothyroxine 125 mcg tablet. Give 1 tablet orally once a day." Review of the MARs for 04/2011 for 04/0/11 through 04/06/11 indicated Resident "C" had received the ordered dose of 125 mcg. The medication cart was checked and the correct dosage supply was observed for Resident "C". All Physicians Orders were			

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	signed as reviewed by 2 nurses and the physician. The Physicians Orders for 02/2011 were signed by the Consultant Pharmacist. All MARs reviewed were signed as reviewed by 2 nurses. The Corporate Nurse was interviewed, in the absence of the DNS (Director Nursing Services), on 04/06/11 at 11:00 a.m. The Corporate Nurse indicated being unaware of the omission of the Kayexalate as ordered and the discrepancy of the Levothyroxine orders. The Corporate Nurse could not verify the medications were			

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	administered as ordered. Review of a Policy and Procedure, titled "Administrative Physician's Orders: 09/2005" provided by the Corporate Nurse on 04/07/11 at 8:45 a.m., indicated: "...2. Transcribe the order to the MAR and/or TAR (Treatment Administration Record) exactly as it was prescribed by the physician..." 3.1-50(a)(1) 3.1-50(a)(2)			